STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 20,360
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Department for Children and Families, Health Access Eligibility Unit, denying Vermont Health Access Program (VHAP) benefits. The issue is whether the petitioner voluntarily dropped health insurance during the twelve months prior to her application.

FINDINGS OF FACT

1. The petitioner lives with her husband and two minor children.

2. The petitioner first sought health care coverage from the Department in March 2006. At that time, the petitioner was eight months pregnant. The petitioner left her employment during February 2006. When petitioner left her employment, her health insurance coverage through her employer stopped. Petitioner and her spouse made the decision that given expected child care expenses for two children, their family economics did not make it sensible for

the petitioner to return to work after the birth of their second child.

3. Petitioner's spouse contacted Maximus with questions. Petitioner and her spouse were concerned that there would be a period in which the petitioner would not be covered during her pregnancy and concerned for subsequent coverage for the petitioner, the newborn baby, and older child. Petitioner's spouse asked whether the petitioner's coverage under Dr. Dynasaur would be affected if he put the petitioner on his health insurance through his employer. He was told there would be no effect.

4. Petitioner and her spouse did not understand that her coverage under Dr. Dynasaur would terminate after the birth of their baby. They were not told that insurance coverage could affect eligibility under the VHAP program. They were not aware of the different medical coverage programs through the Department with their differing eligibility requirements.

5. Petitioner was placed on her spouse's medical insurance on March 1, 2006 and placed on Dr. Dynasaur effective March 1, 2006.

6. Petitioner's baby was born March 31, 2006.

7. Petitioner's spouse receives his health insurance through his employer. Prior to March 2006, only petitioner's spouse was covered through his employer. The employer covered the full health insurance cost of its employee. Once family members are added, the employee is charged $600 per month.

8. Petitioner was only covered one month, March 2006, under her spouse's health insurance. They did not have the funds to maintain her coverage. If they had understood that adding this gap coverage would have negatively impacted the petitioner's continuing eligibility for health coverage through the Department, they would not have added the petitioner to her spouse's insurance for the one month.

9. On April 21, 2006, the Department did a review of petitioner's case resulting in a denial of VHAP on May 5, 2006.[1]

10. At present, the two children are covered by Dr. Dynasaur and the spouse is covered through his employer. Only the petitioner is without health coverage.

ORDER

The Department's decision is reversed.

[1] Petitioner made a timely appeal. Initial conferences were held with one hearing officer who later transferred the case.

REASONS

The Vermont Health Access Plan (VHAP) was created to "provide health care coverage for uninsured or underinsured low income Vermonters". 33 V.S.A. § 1973(b). W.A.M. § 4000.

The state regulation defines uninsured or underinsured as follows:

> Individuals meet this requirement if they do not qualify for Medicare and have no other insurance that includes both hospital and physician services, and did not have such insurance within 12 months prior to the month of application, unless they meet one of the following exceptions below.
>
> (a) Exceptions related to loss of employer-sponsored coverage. . .
>
> (b) Exceptions related to loss of college or university-sponsored coverage. . .
>
> (c) Exceptions related to loss of coverage for low-income applicants. . .
>
> W.A.M. § 4001.2

Before consideration of whether the petitioner's loss of health insurance was voluntary, petitioner raised another argument regarding the fairness of the Department's position. Petitioner maintains that her spouse would not have added her to his health insurance if they had understood that she would then be ineligible for health care coverage from the Department after the birth of their baby. They believe that when petitioner's spouse questioned Maximus about the impact

of private insurance on Dr. Dynasaur, the Maximus representative should have explained that the petitioner's coverage under Dr. Dynasaur would end upon giving birth and should have explained the eligibility requirements of the other health care programs under the Department's aegis.

The Maximus representative correctly answered the specific question asked by petitioner's husband. Having either current health insurance or health insurance during the twelve months prior to application does not affect eligibility for Dr. Dynasaur or for Medicaid. However, the information was not correct regarding the VHAP program.

Petitioner's concern was making sure she had medical coverage during the last month of her pregnancy because she did not know whether there would be Dr. Dynasaur coverage. With correct information about the different Department medical programs, the petitioner and her spouse would have acted differently. They would not have added petitioner to her spouse's health insurance for one month. Then, petitioner could have seamlessly transitioned from Dr. Dynasaur to VHAP.[2]

[2] The Department would still need to determine whether the petitioner met the income guidelines for VHAP.

The Department has argued that the Maximus representative could not have foreseen future contingencies when he spoke to petitioner's spouse. However, the Department's argument misses the point.

Historically, the Department has had an affirmative obligation to inform applicants of eligibility requirements in programs based on cooperative federalism such as ANFC[3] or Medicaid. *Lavigne v. Department of Social Welfare*, 139 Vt. 114 (1980); *Doe v. Wilson, Commissioner of DSW*, Medicare & Medicaid Guide (CCH)¶32,148 at 10,541 (D.Vt. 1982); *Stevens v. Dept. of Social Welfare*, 159 Vt. 408 (1992). More recently, the Agency of Human Services made major structural changes to the Department of Children and Families to encourage looking at applicants and recipients holistically; this includes programs within the Department sharing information and making sure that applicants are aware of the different programs for which they may apply. At the very least, petitioner should have been informed about the different health coverage programs and their requirements so she could make an informed decision as to which programs she would apply.

[3] ANFC (Aid to Needy Families with Children) is a predecessor of Reach Up Financial Assistance.

The Department's failure is a failure of omission. The petitioner was not given incorrect information; she was just not given all the information she needed. Her application should have also been treated as an application for VHAP as she would continue to need medical coverage once the baby was born. The petitioner relied to her detriment on the information she had.[4] The petitioner's application for VHAP should be treated as cotemporaneous with her application for Dr. Dynasaur and for the reasons below should be granted.

The petitioner raised the issue of whether she voluntarily relinquished health insurance.

The Board first considered the adequacy of an earlier version of W.A.M. § 4001.2 in Fair Hearing No. 16,748. The earlier version was found illegal because the regulation did not comport with the requirements of the VHAP waiver[5] that had been approved by the Department of Health and Human Services through its Centers for Medicare and Medicaid Services. In particular, the Board found the regulation conflicted with the VHAP waiver requirement because the regulation eliminated from eligibility persons who had health

[4] The petitioner has an argument that the Department should be equitably estopped from denying petitioner VHAP coverage, but there is no need to reach this argument. See *Stevens v. Dept. of Social Welfare*, supra.
[5] "Vermont Health Access Plan: A Statewide Medicaid Demonstration Waiver Initiative" (February 23, 1995).

insurance during the prior twelve months without considering whether the loss of insurance was voluntary.

Subsequent to Fair Hearing No. 16,748, the Department amended W.A.M. § 4001.2 to further delineate exceptions under loss of employer-sponsored coverage and added subsection c. However, the issues raised in Fair Hearing No. 16,748 continue. Although the Department added provisions exempting some whose loss of insurance was involuntary, the Department's regulation still excludes others who have a legitimate claim that their loss of insurance was involuntary.

The original rationale for the provision excluding those who lost insurance within twelve months of application was to keep employers from dropping health care coverage for their low-wage employees who could then apply for VHAP. *Vermont Health Access Plan: A Statewide Medicaid Demonstration Waiver Initiative*, February 23, 1995, pg.4. Petitioner does not fall within this category. Moreover, the Department did state that they wanted to help low-income Vermonters including working families whose income is "still inadequate to pay private health insurance premiums. . ." *Id*, pg. 1. Petitioner does fall within this category. Private insurance including insurance through her spouse's employer is not

affordable. As petitioner's spouse stated during the fair hearing, the choice would be between paying for insurance and sleeping in their car. Because petitioner did not have the means to pay for health insurance through her husband's employer, her actions should be considered involuntary.

In addition, the Board considered whether the Department's actions conflicted with the Vermont Constitution. The Board took this action based on their knowledge that the Secretary had reversed this issue in an earlier case, Fair Hearing No. 16,414 because the Secretary did not consider their position to be in conflict with federal law. The Secretary subsequently took the same action in Fair Hearing No. 16,748.

The Department is arguing that the Board does not have independent jurisdiction to consider these issues because the Secretary reversed previous board decisions on the same issue pursuant to V.S.A. § 3091(h). However, the Department's reasoning is incorrect. The Board has an independent duty to determine whether the Department's regulation conflicts with state or federal law. 3 V.S.A. § 3091(d); *Stevens v. Dept. of Social Welfare*, supra at page 416. To do otherwise would be an abdication of the Board's responsibility.

The reasoning in Fair Hearing No. 16,748 is adopted herein. The regulation, as amended, continues to exclude those who should not be excluded from coverage—those who are unable to afford health insurance; thus contravening the Common Benefits Clause of the Vermont Constitution. Vt. Const., Ch I, Art. 7.

Accordingly, the Department's decision denying VHAP is reversed.

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